

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

10877

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10861

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgeley</b> 85X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>30 Carpenter Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Richard</b> Last <b>Adams</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1959</b>
9. AGE (In years last birthday) <b>1</b> yrs. <b>8</b> mos. <b>20</b> days		IF UNDER 1 YEAR Months <b>8</b> Days <b>20</b>	
IF UNDER 24 HRS. Hours <b>11</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Jr. Adams</b>		14. MOTHER'S MAIDEN NAME <b>Anna Mae Zies</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. John Adams</b>		Address <b>Ridgeley, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE CARDIAC FAILURE (HEMOTHORAX)</b> 3-4 Days DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CARDIAC HYPERTROPHY; CONGENITAL PUL-</b> (c) <b>MONARY STENOSIS; ADRENAL ATROPHY</b> cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>OCTOBER 21, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/24/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Forrest Glenn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Green Spring, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 25 '60</b>		DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>			

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU IN CHARGE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10001

(M)

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		M		45		JAN 10, 1900		CHICAGO		ILLINOIS		COOK		ILLINOIS	
OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		RELIGION		RACE		COLOR		HAIR	
Carpenter		High School		Married		None		Catholic		White		White		Brown	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
None		Heart Failure		Natural		Home		JAN 15, 1945		10:30 AM		10:30		10:30	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		COUNTY		STATE		FEE		TAX	
J. H. HARRIS		JAN 15, 1945		Home		CHICAGO		COOK		ILLINOIS		\$1.00		\$0.00	
SIGNATURE OF WITNESS		DATE OF WITNESS		PLACE OF WITNESS		CITY		COUNTY		STATE		FEE		TAX	
J. H. HARRIS		JAN 15, 1945		Home		CHICAGO		COOK		ILLINOIS		\$1.00		\$0.00	

10878

MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10862

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
c. LENGTH OF STAY IN 1b <b>10 days</b>				d. STREET ADDRESS <b>50 N. MECHANIC STREET</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CLYDE</b> Middle <b>Alphonso</b> Last <b>APPOLD</b>				4. DATE OF DEATH Month <b>10</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 9, 1901</b>		9. AGE (In years last birthday) <b>59</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Queen City Brewery</b>		11. BIRTHPLACE (State or foreign country) <b>Magnolia, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM Z. APPOLD (D)</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. STOTT (D)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-4986</b>		17. INFORMANT <b>Mr. Donald C. Appold</b> Address <b>937 Md. Ave., Cumb. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO <b>hepatic coma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>craniom of the liver</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-15-1960</b> to <b>10-30-1960</b> , that (I) (we) last saw the deceased alive on <b>10-30-1960</b> , and that death occurred at <b>6</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Brings</b>				22b. DATE <b>10/31/60</b>		22c. PHYSICIAN'S NAME (Type) <b>LOUIS BRINGS, M.D.</b>	
22d. ADDRESS <b>57 GREENE ST., CUMBERLAND, MD.</b>				22e. DATE <b>NOV 2 '60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/1/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18882

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10863**

**10879**

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>10 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLERSLIE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Ross</b> Middle <b>BAGLEY</b> Last <b>BAGLEY</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>14</b> Year <b>19 60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 10, 1887</b>		
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b>		IF UNDER 24 HRS. Hours <b>14</b> Min. <b>19</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>PRR Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Bedford, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Bagley</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Spiece</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>716-10-6687</b>		17. INFORMANT <b>Ross Bagley, Jr., Severna Park, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (c) <b>DUE TO</b> (a) <b>stating the underlying cause lost.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 Hr.</b> <b>----</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Benedict Skitabelic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>BENEDICT SKITABELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>OCTOBER 14, 1960</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 18, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cooks Mills Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyndman, Pa. RD#1</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Zeigler</b>				ADDRESS <b>Hyndman, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 19 '60</b>		
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registering officer prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10864

10880

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>ALLEGANY</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>19 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL AVE.</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MELVIN</b> Middle <b>BARBER</b> Last <b>BARBER</b>				<b>4. DATE OF DEATH</b> Month <b>OCTOBER</b> Day <b>28</b> Year <b>19 60</b>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>APRIL 23, 1914</b>	
<b>9. AGE</b> (In years last birthday) <b>46 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.		<b>IF UNDER 24 HRS.</b> Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Tavern Operated</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Tavern Operated</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>GILMORE, MD.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>RALPH BARBER</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>JENNIE MUIR</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>CORONARY SCLEROSIS WITH OCCLUSION, LEFT</b> <b>420.1</b> <b>DUE TO</b> <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 Hr.</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>CIRRHOSIS OF THE LIVER</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour <b>o. m.</b> <b>p. m.</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <i>Benedict Skitarelic</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <b>BENEDICT SKITARELIC, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10/31/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. View Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Moscow, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>George Eichhorn</b>				<b>ADDRESS</b> <b>Lonaconing, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE NOV 1 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Thayer</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. Medical Examiner's Certificate of Death

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

10881

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10865

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>6 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL AVE.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRANTSVILLE 11X-2</b> d. STREET ADDRESS <b>GRANTSVILLE 11X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHRISTINE M BENDER</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 7 19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 2, 1906</b>
9. AGE (In years last birthday) <b>54</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>	
11. BIRTHPLACE (State or foreign country) <b>CELLIN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHRISTIAN BEACHY</b>		14. MOTHER'S MAIDEN NAME <b>ALENA J. BITTINGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>215-42-4222</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) <b>Hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumberland Allegany MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>10/3/60</b> 19____, to <b>10/7/60</b> 19____, that (I) (we) lost saw the deceased alive on <b>10/7/60</b> 19____, and that death occurred on <b>10/7/60</b> 19____ at <b>3:15PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>		22d. ADDRESS <b>Cumberland Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/10/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GRANTSVILLE</b>		23d. LOCATION (City, town, or county) (State) <b>GRANTSVILLE GARRETT COMD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Don Newman, Grantsville, MD</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 13 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			



10885

CERTIFICATE OF DEATH

10885

DECEASED

NAME

ALICE

GRANTVILLE

AGE

CUMBERLAND

GENERAL HOSPITAL, CUMBERLAND, MD.

OCTOBER 1960

SEX

CHRISTIAN

AUGUST 2, 1908

WHITE

FEMALE

ELLIN, WYLAND

ALICE A. BITTNER

CHRISTIAN CHURCH

2101 N. WYLAND, CUMBERLAND, MD.

DR. R. A. WILLIAMS



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**10882****CERTIFICATE OF DEATH****10866**

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>9/17/60</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nell</b> Middle <b>P.</b> Last <b>Berkenbaugh</b>				4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/10/1875</b>	
9. AGE (In years lost birthday) <b>85</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Leopold Berkenbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Rowan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>P.O.Box 599, Allegany County Infirmary Records</b> Address <b>Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> DUE TO <b>General arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Secondary anemia</b> DUE TO (c) <b>Senile psychosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/17/60</b> 19____, to <b>10/17/60</b> 19____, that (I) (we) last saw the deceased alive on <b>10/17/60</b> 19____, and that death occurred at <b>5:15 P.M.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James E. McLean</b>				22b. DATE SIGNED <b>10/18/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>	
22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/20/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lonaconing, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>				25. REC'D BY REGISTRAR <b>LONACONING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

may be reviewed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10882

Allegany

Allegany County, Maryland

10/17/80

Allegany County, Maryland

Hell

Female White

Footnote: None

Joseph Berkenburg

Ernest Roman

10/10/80

F. Berkenburg

15 Island Street

Allegany

10882

Allegany

CERTIFICATE OF DEATH

Allegany

10/17/80

10/17/80

10/17/80

10/18/80

James E. Nelson

15 Greene St., Chesapeake, Md.

10/10/1980

Allegany

Allegany County, Maryland

Allegany County, Maryland

10927

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10867

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>				c. LENGTH OF STAY IN lb <b>18 HRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MINERS HOSPITAL</b>				d. STREET ADDRESS <b>201 CENTER ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>JOHN</b>		Middle <b>S.</b>		Last <b>BLAKE</b>	
4. DATE OF DEATH <b>OCTOBER 1, 1960</b>		Month <b>OCTOBER</b>		Day <b>1</b>		Year <b>1960</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 15, 1890</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PIPE FITTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE CORP.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PHILLIP BLAKE</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET BEAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-07-6145</b>		17. INFORMANT Address <b>MRS. CLARA BLAKE, FROSTBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO <b>422.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>6404</b> (c) <b>Diabetes</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6404</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 6, 1960</b> to <b>Oct 1, 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct 1, 1960</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W O McLane</b>		M.D. <b>W. O. McLane, M. D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Oct 3 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>		22d. ADDRESS <b>E. MAIN ST., FROSTBURG, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10-3-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Bursst</b>		ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>OCT 4 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Hume</b>	

10007

CERTIFICATE OF DEATH

10007

*[Faint, mostly illegible text and lines on a death certificate form. The form includes fields for name, date of birth, date of death, and cause of death. There are also sections for the attending physician and the funeral home. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10868

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital (DOA)</b>				d. STREET ADDRESS <b>1 147 Hanover St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>M.</b> Last <b>Boston</b>				4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 11, 1905</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min.		IF UNDER 24 HRS. Hours <b>27</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Douglas Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Yonker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. William Walker</b> Address <b>Pittsburg, Pennsylvania</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (c) <b>CORONARY SCLEROSIS</b> DUE TO <b>CORONARY SCLEROSIS</b> (c) <b>CORONARY SCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>						INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>**---</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>October 25, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct., 28, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sumner Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kous Stein Inc</b>				ADDRESS <b>117 Frederick St. Cumb. Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 27 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			







TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10884

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10869

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>10 Da.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>21 Harrison St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Ethel</b> Last <b>Boward</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>21</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1879</b>		9. AGE (In years last birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Leonard R. Boward</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Mock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Aletha Kerns Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE CARDIAC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURE OF LEFT HIP</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL OF CHAIR AT HOME</b>					
20c. TIME OF INJURY Month, Day, Year <b>10:30 a.m. Oct. 11 1960</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>October 21, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/24/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 25 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles L. George</b>			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		M		45		10/10/1964		BOSTON, MASS.	
MOTHER'S NAME		FATHER'S NAME		MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE TYPE	
JANE J. JONES		JOHN J. JONES		1915		BOSTON, MASS.		CIVIL	
EDUCATION		OCCUPATION		RELIGION		RACE		ETHNIC ORIGIN	
HIGH SCHOOL		LABORER		CATHOLIC		WHITE		IRISH	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		EXAMINER'S SIGNATURE	
NONE		HEART DISEASE		NATURAL		1086		JAMES J. JONES	
DATE OF EXAMINATION		PLACE OF EXAMINATION		EXAMINER'S TITLE		EXAMINER'S ADDRESS		EXAMINER'S PHONE	
10/10/1964		BOSTON, MASS.		M.D.		1234 MAIN ST.		123-4567	
DATE OF REPORT		PLACE OF REPORT		REPORTER'S NAME		REPORTER'S ADDRESS		REPORTER'S PHONE	
10/10/1964		BOSTON, MASS.		JANE J. JONES		1234 MAIN ST.		123-4567	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10885

10870

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>57 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>HERMAN</b> Last <b>BROWNING</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 22, 1897</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>FLINTSTONE, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>EPHRAIM BROWNING</b>				14. MOTHER'S MAIDEN NAME <b>CLARA HAMILTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-36-9864</b>		17. INFORMANT <b>Mrs. Willa H. Browning</b> Rt. 2 Address <b>Flintstone, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerotic Hypertension Contributing Cause</b> (c) <b>years.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval BETWEEN ONSET AND DEATH</b> <b>minutes.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>60</b> , to <b>Oct</b> 19 <b>60</b> , that (I) <b>we</b> last saw the deceased alive on <b>Oct 7</b> 19 <b>60</b> , and that death occurred at <b>12:25 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>G. Overton Himmelwright</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>G. OVERTON HIMMELWRIGHT</b>				22d. ADDRESS <b>1331 Virginia Ave, Cumberland, Md 21610</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b> ADDRESS				25a. REC'D BY REGISTRAR <b>OCT 17 '60</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Haas</b>	

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## 10886

1087

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>26 DAYS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL AVE.</b>						d. STREET ADDRESS <b>406 PULASKI ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM H. BULEY</b>						4. DATE OF DEATH Month Day Year <b>OCTOBER 14 1960</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 27, 1883</b>		9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>City Employee</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Flintstone</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>JAMES M. BULEY</b>						14. MOTHER'S MAIDEN NAME <b>JULIA DIEHL</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>											
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic cardiovascular disease</b> <b>422-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>Since July 1st</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>7.16.1944</b> to <b>10.14.60</b> saw the deceased alive on <b>10.14.60</b> , and that death occurred at <b>6:00 PM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>DR. W. F. WMS.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>10/15/60</b>					
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WMS.</b>						22d. ADDRESS <b>Cumberland Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10/17/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10887

10872

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GLADYS</b> Middle <b>BURKETT</b> Last <b>BURKETT</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 13, 1910</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE &amp; Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ladies Hosiery</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES STAUP</b>		14. MOTHER'S MAIDEN NAME <b>GRACE WADDELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-16-2053</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart cell Lymphoblastoma with</b> <b>202.1</b> DUE TO <b>Intensive generalized convulsions</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive and arteriosclerotic vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>18m.</b> to <b>6 oct.</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>5 oct.</b> 19 <b>60</b> and that death occurred at <b>6:25 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. Alfred Van Ormer</b>		22b. DATE SIGNED <b>6 oct. 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>		22d. ADDRESS <b>122 S. Centre St. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/8/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park,</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>Carter S. Hines</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Carter S. Hines</b>	

VR A15 (4)  
15M 9/59

10887

CERTIFICATE OF DEATH

10887

ALLIANCE

WYLAND

ALLEGANY

CUMBERLAND

ELDER

CUMBERLAND

1557 BRADDOCK ROAD

GENERAL HOSPITAL

OCTOBER 8 1950

GLADYS

WHITE FEMALE

HOXBERRY, JAMES

JAMES STARR

GENERAL HOSPITAL - CUMBERLAND, MARYLAND

DR. W. J. VAN COTT

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10887

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10939**  
**CERTIFICATE OF DEATH**

**10873**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Allegany</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home 160 Queen St.</u>				d. STREET ADDRESS <u>160 Queen</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Harry</u> Middle <u>Clifford</u> Last <u>Cain</u>				<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>12</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u>17</u> Min. <u>17</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rail Road Brakeman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>		11. BIRTHPLACE (State or foreign country) <u>Keyser, W. Va.</u>	
13. FATHER'S NAME <u>Goff Cain</u>				14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-07-9703</u>		17. INFORMANT <u>Lillian Tharp Cain, McCoole, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Arteriosclerosis</u> (b) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Rheumatoid Arthritis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>past 4 months</u>	
20f. (City or town) <u>Keyser, W. Va.</u>				(County) <u>Allegany</u>		(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>past 4 months</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/10</u> , 19 <u>60</u> , and that death occurred at <u>10/10</u> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Keyser, W. Va.</u> DATE SIGNED <u>Paul T. Healy</u>							
ACTUAL SIGNATURE <u>Paul T. Healy</u> M.D. <u>Keyser, W. Va.</u>							
PHYSICIAN'S NAME (Type) <u>Paul T. Healy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-15-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Valley Memorial Gardens Inc.</u>		22d. LOCATION (City, town, or county) (State) <u>Keyser, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Smith Jr.</u>				ADDRESS <u>Keyser, W. Va.</u>		24a. REC'D BY REGISTRAR <u>OCT 17 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>				DATE <u>OCT 17 '60</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Allegany

Allegany

McCole

McCole

Joe Green

Home 100 Green St.

Clifford Cain

Henry

Male

White

Dec. 22, 1898

Rever, W. A.

Half Road

Half Road

Harry Brown

Post Cain

705-07-9703 Lillian Tharp Cain, McCole, Md.

(Wife)

No

No

Rever, W. A.

Paul E. Henry

Rever, W. A.

Rever, W. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10888  
CERTIFICATE OF DEATH

Reg. Dist. No. 10874

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland.</b>				c. LENGTH OF STAY IN 1b <b>62</b> <b>Cumberland.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Water St.,</b>				d. STREET ADDRESS <b>11 Water St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>BENEDICT</b> Last <b>CESSNA</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 18, 1896</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min. <b>64</b>		IF UNDER 24 HRS. Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min. <b>64</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caller</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>W. Md. Rwy.</b>		11. BIRTHPLACE (State or foreign country) <b>Cresaptown, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William Cessna</b>				14. MOTHER'S MAIDEN NAME <b>Sara A. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mr. Elmer E. Cessna Bedford Rd. Cumb. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary Heart Disease</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11 - 28</b> , 19 <b>60</b> , to <b>10 - 27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>10 - 27</b> , 19 <b>60</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Greene St.,</b> DATE SIGNED <b>10-28-60</b>							
ACTUAL SIGNATURE <b>Ralph W. Ballin</b> M.D.				PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin M.D.</b> <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/31/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

0888

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u> years</p>	
<p>4. Date of death: <u>Jan 15, 1920</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>Dr. J. H. Smith</u></p>	
<p>8. Signature of registrar: <u>John Doe</u></p>	
<p>9. Date of registration: <u>Jan 16, 1920</u></p>	
<p>10. Place of burial: <u>Cemetery</u></p>	
<p>11. Name of funeral home: <u>None</u></p>	
<p>12. Remarks: <u>None</u></p>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

10940

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10875

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>		c. LENGTH OF STAY IN lb <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 4,</u>				d. STREET ADDRESS <u>Route 4,</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARETHA</u> Middle <u>W.</u> Last <u>CHANEY</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>11</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1905</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Luhnow</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Kuchenbecker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Harold B. Chaney, Route 4, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u>    </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>    </u> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>    </u> a. m. <u>    </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>OCTOBER 11, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter &amp; Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

10928

10876

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>13 High Street</u>				d. STREET ADDRESS <u>13 High Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Ronald</u> Last <u>Cosgrove</u>				4. DATE OF DEATH Month <u>October</u> Day <u>31st</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9th, 1896</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>64</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.-City Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thoma s Cosgrove</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 1 217-10-5159</u>		17. INFORMANT Address <u>Mrs. Zura Cosgrove, 13 High St. F'bg. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute lymphatic leukemia,</u> DUE TO (b) <u>204.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) <u>Secondary anemia.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-1</u> <u>1960</u> , to <u>10-31</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>10-31</u> <u>1960</u> and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>H. C. Diehl</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/1/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. C. Diehl,</u>		22d. ADDRESS <u>39 W. Main St., Frostburg, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-2-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Burt</u>				ADDRESS <u>Frostburg, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 3 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>			

1581

2980

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10889

10877

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>525 Eastern Ave.</b>		d. STREET ADDRESS <b>525 Eastern Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>MARY</b> Last <b>CROSS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1879</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Morgan County, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Sheppard</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Lowman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Francis Atkinson</b>		Address <b>Cumberland, Md.</b> <b>525 Eastern Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>OCTOBER 21, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 23, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 24 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			



10873

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

40883

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "JAN 15 1945"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "HOME"]	
OCCUPATION [Faint text, possibly "Carpenter"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF MEDICAL EXAMINER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF NEXT OF KIN [Faint signature]	
CITY [Faint text, possibly "BALTIMORE"]		COUNTY [Faint text, possibly "BALTIMORE"]		STATE [Faint text, possibly "MD"]	

1

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10929

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10878

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				d. STREET ADDRESS <b>1 (Gunter Hotel) W. Main St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Willard Davis</b>				4. DATE OF DEATH Month Day Year <b>October 14th, 19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 31st, 1899</b>		9. AGE (In years lost birthday) <b>61 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Band Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Sprf. Tire Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John R. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. House</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>712-14-1665</b>		17. INFORMANT <b>Mrs. Cleo D. Henry, 168 Spring St., F'bg. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443x Congestive Heart failure</b> DUE TO (b) <b>Hypertensive Cardiovascular dis.</b> DUE TO (c) <b>years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 wks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>may 1949</b> to <b>Oct 14, 1960</b> that (I) (we) last saw the deceased alive on <b>Oct 14, 1960</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John B. Davis,</b>				22b. DATE SIGNED <b>10/15/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>John B. Davis,</b>				22d. ADDRESS <b>2 Broadway, Frostburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-17-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. R. Burt</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 18 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

1967

CERTIFICATE OF DEATH

1967



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10879**

**10890**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>			c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>211 So. Spruce St.,</b>				d. STREET ADDRESS <b>211 So. Spruce St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-around;"> <span>First <b>JOHN</b></span> <span>Middle <b>EARL</b></span> <span>Last <b>DAVIS</b></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-around;"> <span>Month <b>Oct.</b></span> <span>Day <b>30th</b></span> <span>Year <b>1960</b></span> </div>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 3, 1903</b>	
<b>9. AGE</b> (In years last birthday) <b>57</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cook</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Restaurant</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>North Branch, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Charles H. Davis</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Nellie Virginia Twigg</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-10-7330</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Mrs. A. H. Bloss Bowmans Add. Cumb. Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a) CORONARY OCCLUSION</b>  <b>420.1 DUE TO</b>  <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) CORONARY SCLEROSIS</b>  <b>(c) DUE TO</b> </div>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>SUDDEN</b>  ---	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour o. m. p. m. <span style="float: right;">19</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <span style="float: right;">(County) (State)</span>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>Benedict Skitarelic</i> <span style="float: right;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>BENEDICT SKITARELIC, M.D.</b>				<b>DATE SIGNED</b> <b>OCTOBER 30, 1960</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>11/2/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Zion Memorial Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> <span style="float: right;">(State)</span> <b>Cumberland, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H. Wayne George</b> <span style="float: right;">ADDRESS <b>Cumberland, Md.</b></span>				<b>24a. REC'D BY REGISTRAR</b> <b>NOV 2 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Hanes</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

10941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film G273 10-18-60 et

Reg. Dist. No. 10880

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Luke, Md.</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Md. 28, 0352.2</b>		d. STREET ADDRESS <b>1922 Beverly Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>W. Va. Pulp &amp; Paper Co.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>J.</b> Last <b>De Armey</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1915</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse</b>	
11. BIRTHPLACE (State or foreign country) <b>Windber, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mc Clellan De Armey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bossick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>War II</b>		16. SOCIAL SECURITY NO. <b>206-07-2045</b>	
17. INFORMANT <b>George A. Farley, Baltimore, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC ARREST</b> <b>914.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ELECTROCUTION</b> (a), stating the underlying cause lost. DUE TO (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 Min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>Working with electric motor</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>7:45 a.m. Oct. 9 1960</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>W. Va. Pulp &amp; Paper Luke</b>		20f. (City or town) (County) (State) <b>Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>October 9(9) 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-13-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Richland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Richland, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>OCT 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the funeral director.

VR A15 (4)  
15M 9/59

10930

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10881

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>	c. LENGTH OF STAY IN 1b <b>1 WEEK</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MINERS HOSPITAL</b>		e. STREET ADDRESS <b>CHURCH HILL</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>N.</b> Last <b>DEFFENBAUGH</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>31</b> , Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 20, 1886</b>
9. AGE (In years lost birthday) yrs. <b>74</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN ENGINEERING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE CORP.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN G. DEFFENBAUGH</b>		14. MOTHER'S MAIDEN NAME <b>JANE HITCHINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>1</b>		16. SOCIAL SECURITY NO. <b>214-07-1458</b>	
17. INFORMANT <b>MRS. EDW. DEFFENBAUGH, MT. SAVAGE, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Coronary Thrombosis - Wasm</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Myocardial Infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>X</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>X</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>		20f. (City or town) (County) (State) <b>X</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>10/24</b> 19 <b>60</b> , to <b>10/31</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>10/31</b> 19 <b>60</b> , and that death occurred at <b>6:58 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin Rothstein, M.D.</b>		22b. DATE SIGNED <b>11/1/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN ROTHSTEIN, M. D.</b>		22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-3-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>METHODIST CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MT. SAVAGE, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. R. Covert</b>		25a. REC'D BY REGISTRAR <b>NOV 3 '60</b>	
ADDRESS <b>FROSTBURG, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frame</b>	

10831

CERTIFICATE OF DEATH

10831

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10942

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10882

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Archibald Dixon</b>				4. DATE OF DEATH Month Day Year <b>October 16 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 20, 1898</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Baker</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>James Dixon</b>				14. MOTHER'S MAIDEN NAME <b>Ida Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-01-6079</b>		17. INFORMANT Address <b>Mrs. Arch Dixon Midland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>years</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 13, 1960</b> to <b>Oct 15, 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct. 5, 1960</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L. R. Miles, M.D.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-17-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. R. MILES, JR., M.D.</b>				22d. ADDRESS <b>LONA CONING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumbarland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 19 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



10885

CERTIFICATE OF DEATH

10948

(M)

Allegany

Maryland

Allegany

Maryland

Maryland

October 10 1900

Allegany

Allegany

Allegany

November 10, 1900

Allegany

Allegany

Allegany, Maryland, U.S.A.

Allegany, Maryland

The Baker

James Dixon

Allegany, Maryland

Allegany, Maryland

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Allegany

may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10931

10883

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			c. LENGTH OF STAY IN 1b <b>10 Hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				d. STREET ADDRESS <b>1 74 Grant Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>J.</b> Last <b>Dunn</b>				4. DATE OF DEATH Month <b>October</b> Day <b>21st</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 9th, 1908</b>	
9. AGE (In years last birthday) <b>52 yrs.</b>		10. UNDER 1 YEAR Months <b>52</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman-Store Room</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Hugh Dunn</b>				14. MOTHER'S MAIDEN NAME <b>Alice Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-6798</b>		17. INFORMANT <b>Mrs. Ursula C. Dunn, 74 Grant St., F'bg. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO <b>Corrosion of liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>Oct 21, 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct 21, 1960</b> , and that death occurred at <b>11:37 P.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>W. O. McLane</b>		22b. PHYSICIAN'S NAME (Type) <b>W. O. McLane</b>		22c. ADDRESS <b>167 E. Main Street, Frostburg, Md.</b>		22d. DATE <b>Oct 24 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-25-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. H. Durrant</b>				25a. REC'D BY REGISTRAR <b>Oct 26 60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

10883

CERTIFICATE OF DEATH

10883

10883

1

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

10891

10884

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>119 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FLINTSTONE</b>		d. STREET ADDRESS <b>Route 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>AMANDA</b>		First <b>A.</b>		Middle <b>DU VALL</b>		Last <b>DU VALL</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 11</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Spring Gap</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. AMERICA</b>	
13. FATHER'S NAME <b>GEORGE GARLAND</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH DAVIS</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancerous of cervix</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>Oct 5</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct 5</b> , 19 <b>60</b> , and that death occurred at <b>6:45pm</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>DR. DONALD GROVE</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-7-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. DONALD GROVE</b>		M.D.		22d. ADDRESS <b>122 S. Centre St. Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Allegany County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

10884

CERTIFICATE OF DEATH

10884

ALLIANCE

WILLIAM

ALLIANCE

ELIZABETH

119 DAYS

ON DEATH

MEMORIAL HOSPITAL, MEMORIAL AVE.

OCTOBER 2

ON WILL

WILLIAM

WHITE

WHITE

U. S. A. 11

WILLIAM

GEORGE GIRLAND

ELIZABETH DAVIS

QUEENSLAND, HAWAII

MEMORIAL HOSPITAL

DR. DONALD GROVE



10932

CERTIFICATE OF DEATH

10885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners</u>				d. STREET ADDRESS <u>Miners Hospital</u>			
3. NAME OF DECEASED (Type or print) First <u>Tammy</u> Middle <u>Theres</u> Last <u>Emmatt</u>				4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-60</u>	
9. AGE (In years last birthday) yrs. <u>33</u>		IF UNDER 1 YEAR Months <u>33</u> Days <u>33</u> Hours <u>33</u> Min. <u>33</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert Bruce Emmatt</u>				14. MOTHER'S MAIDEN NAME <u>Harriett K. Holsinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Robert Bruce Emmatt, Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Premature birth</u> 761.5 DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Premature separation of placenta</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-2</u> , 19 <u>60</u> , to <u>10-2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10-2</u> , 19 <u>60</u> , and that death occurred at <u>4</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.C. Diehl</u>				ADDRESS (Street, city or town, state) <u>39 W. Main St. Frostburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>				DATE SIGNED <u>10/2/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-3-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Frostburg, Md.</u>				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. H. Barrett</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Christina L. Harris</u>				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2061151XV0

48291

28201



1100

1100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10937

## CERTIFICATE OF DEATH

10887

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Alleganey</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Alleganey</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		c. LENGTH OF STAY IN 1b <b>4Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 Potomac St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>M. Greenan</b> Last <b></b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4. 1883</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Hancock, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Murray</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs Ann Murray</b> Address <b>Westernport, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial degeneration</b> DUE TO <b>422-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December, 1958</b> , to <b>Oct. 6, 1960</b> , that I last saw the deceased alive on <b>October 6, 1960</b> , and that death occurred at <b>1 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Piedmont, West Va.</b> DATE SIGNED <b>10/7/60</b>			
ACTUAL SIGNATURE <b>James H. Wolverton, Sr.</b>		M.D. <b></b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 10, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Peters Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Harold Fredlock, Piedmont W. Va.</b>		ADDRESS <b></b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



CERTIFICATE OF DEATH

10887

10887

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PRESENT ADDRESS</p> <p>12. DATE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. CAUSE OF DEATH</p> <p>15. MANNER OF DEATH</p> <p>16. SIGNATURE OF PHYSICIAN</p> <p>17. SIGNATURE OF REGISTRAR</p> <p>18. SIGNATURE OF WITNESSES</p> <p>19. SIGNATURE OF DECEASED</p> <p>20. SIGNATURE OF NEXT OF KIN</p> <p>21. SIGNATURE OF CLERK</p> <p>22. SIGNATURE OF JUDGE</p> <p>23. SIGNATURE OF SHERIFF</p> <p>24. SIGNATURE OF CORONER</p> <p>25. SIGNATURE OF JURY</p> <p>26. SIGNATURE OF COURT</p> <p>27. SIGNATURE OF STATE</p> <p>28. SIGNATURE OF UNION</p> <p>29. SIGNATURE OF COUNTY</p> <p>30. SIGNATURE OF CITY</p> <p>31. SIGNATURE OF TOWNSHIP</p> <p>32. SIGNATURE OF PARISH</p> <p>33. SIGNATURE OF VILLAGE</p> <p>34. SIGNATURE OF HAMLET</p> <p>35. SIGNATURE OF COTTAGE</p> <p>36. SIGNATURE OF HOUSE</p> <p>37. SIGNATURE OF FARM</p> <p>38. SIGNATURE OF PLANTATION</p> <p>39. SIGNATURE OF ESTATE</p> <p>40. SIGNATURE OF TRUST</p> <p>41. SIGNATURE OF COMPANY</p> <p>42. SIGNATURE OF CORPORATION</p> <p>43. SIGNATURE OF SOCIETY</p> <p>44. SIGNATURE OF ORDER</p> <p>45. SIGNATURE OF CONGREGATION</p> <p>46. SIGNATURE OF CHURCH</p> <p>47. SIGNATURE OF SYNAGOGUE</p> <p>48. SIGNATURE OF MOSQUE</p> <p>49. SIGNATURE OF TEMPLE</p> <p>50. SIGNATURE OF MONASTERY</p> <p>51. SIGNATURE OF CONVENT</p> <p>52. SIGNATURE OF PRIORY</p> <p>53. SIGNATURE OF ABBEY</p> <p>54. SIGNATURE OF BISHOPRIC</p> <p>55. SIGNATURE OF ARCHBISHOPRIC</p> <p>56. SIGNATURE OF DIOCESE</p> <p>57. SIGNATURE OF PARISH</p> <p>58. SIGNATURE OF RECTORY</p> <p>59. SIGNATURE OF VICARAGE</p> <p>60. SIGNATURE OF CHANCEL</p> <p>61. SIGNATURE OF ALTAR</p> <p>62. SIGNATURE OF PULPIT</p> <p>63. SIGNATURE OF AMBON</p> <p>64. SIGNATURE OF TABERNACLE</p> <p>65. SIGNATURE OF SACRISTY</p> <p>66. SIGNATURE OF CHURCHYARD</p> <p>67. SIGNATURE OF CEMETERY</p> <p>68. SIGNATURE OF BURIAL</p> <p>69. SIGNATURE OF INTERMENT</p> <p>70. SIGNATURE OF CREMATION</p> <p>71. SIGNATURE OF URN</p> <p>72. SIGNATURE OF COFFIN</p> <p>73. SIGNATURE OF CASKET</p> <p>74. SIGNATURE OF CASK</p> <p>75. SIGNATURE OF BOX</p> <p>76. SIGNATURE OF CHEST</p> <p>77. SIGNATURE OF CUPBOARD</p> <p>78. SIGNATURE OF CASE</p> <p>79. SIGNATURE OF COMPARTMENT</p> <p>80. SIGNATURE OF DRAWER</p> <p>81. SIGNATURE OF DOOR</p> <p>82. SIGNATURE OF WINDOW</p> <p>83. SIGNATURE OF WALL</p> <p>84. SIGNATURE OF FLOOR</p> <p>85. SIGNATURE OF CEILING</p> <p>86. SIGNATURE OF ROOF</p> <p>87. SIGNATURE OF GROUND</p> <p>88. SIGNATURE OF AIR</p> <p>89. SIGNATURE OF WATER</p> <p>90. SIGNATURE OF FIRE</p> <p>91. SIGNATURE OF LIGHT</p> <p>92. SIGNATURE OF SOUND</p> <p>93. SIGNATURE OF SMELL</p> <p>94. SIGNATURE OF TASTE</p> <p>95. SIGNATURE OF TOUCH</p> <p>96. SIGNATURE OF FEELING</p> <p>97. SIGNATURE OF THOUGHT</p> <p>98. SIGNATURE OF EMOTION</p> <p>99. SIGNATURE OF ACTION</p> <p>100. SIGNATURE OF REACTION</p>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10943 Item 7 Film G274 11-4-60 et  
CERTIFICATE OF DEATH

Reg. Dist. No. 10888

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.D. #2, Frostburg, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. #2, Box 82, Frostburg, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALICE</b> First <b>HAYES</b> Middle <b>HARRIS</b> Last		4. DATE OF DEATH Month <b>10</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-1893</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>29</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>6</b> Days <b>29</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Midlothian, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Price Hayes</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Winebrenner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Arthur Harris, R.D. #2, Box 88,</b>		Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arterio-sclerotic cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1 1/2 years</b> (c) <b>1 1/2 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 10, 1960</b> , to <b>10-29, 1960</b> , that I last saw the deceased alive on <b>10-28, 1960</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H.C. Diehl</b> M.D.		ADDRESS (Street, city or town, state) <b>39 W. Main St. Frostburg, Md.</b>	
DATE SIGNED <b>10/31/60</b>			
PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/31/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Percy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Montague</b>		24. REC'D BY REGISTRAR <b>NOV 2 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

1058

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be filed with the State Board of Health prior to burial, cremation, or removal, and many event, within 72 hours after death. Page 2 should be filled with the funeral director.

VR A15 (4)  
ISM 9/59

10933

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10889

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Harris</b> Last <b>Harris</b>				4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. UNDER 1 YEAR Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Business Man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Market</b>			
13. FATHER'S NAME <b>Joseph Harris</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Prichard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-32-3161A</b>			
17. INFORMANT <b>Mrs. Boyd Bolyard</b>				Address <b>Lonaconing, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO <b>lyng cause lost.</b> DUE TO <b>lyng cause lost.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Laparotomy for intestinal obstruction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 3, 1956</b> to <b>Oct. 23, 1960</b> that (I) (we) last saw the deceased alive on <b>Oct. 23, 1960</b> , and that death occurred at <b>11:15 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L.R. Miles, Jr.</b>				22b. DATE SIGNED <b>10-24-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>				22d. ADDRESS <b>LONA CONING MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10/25/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	
23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>				23e. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				25a. REC'D BY REGISTRAR <b>OCT 27 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				25c. DATE <b>OCT 27 '60</b>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10893

10890

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOYCE</b> First <b>LEE</b> Middle <b>HOUSE</b> Last		4. DATE OF DEATH <b>OCTOBER 8 1960</b> Month <b>OCTOBER</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 4, 1960</b>
9. AGE (In years lost birthday) yrs. <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> IF UNDER 24 HRS. Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE P. HOUSE</b>		14. MOTHER'S MAIDEN NAME <b>DORIS ARNOLD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT (Father) <b>George P. House, Harris Apts.,</b>		Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.0</b> DUE TO <b>Cerebral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cholelithiasis &amp; Patent Ductus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred <b>9:20 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-10-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>		25a. REC'D BY REGISTRAR <b>23 East Main, Frostburg, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		OCT 14 '60	

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ALLIANCE

CORRECTION

SPECIAL INVESTIGATION

OCTOBER 1960

OCTOBER 1960

GEORGE T. HUGHES



*Handwritten signature or initials*

10-10-60

10-10-60

10-10-60



10894  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

10891

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>60yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>128 Monroe Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>B. Hymes</b> Last <b></b>				4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/ 26/ 97</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired U.S. Postal</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation Serv Maryland Flintstone</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Phillip Hymes (D)</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Smith (D)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>War I</b>				16. SOCIAL SECURITY NO. <b>213-40-3599</b>			
17. INFORMANT <b>Irene Isabelle Hymes</b> Address <b>128 Monroe St</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hepatic coma</b> DUE TO <b>liver cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) lost the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Brings</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-22-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Brings</b>				22d. ADDRESS <b>57 Greene St. Cumberland Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-24-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 26 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**10895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **10892**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>149 Polk St.,</b>				d. STREET ADDRESS <b>/ 149 Polk St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dorsey</b> Middle <b>Edward</b> Last <b>Jefferys</b>				4. DATE OF DEATH Month <b>October</b> Day <b>11</b> , Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 3, 1897</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Train Dispatcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>		11. BIRTHPLACE (State or foreign country) <b>Altamont, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alfred Jefferys</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Warnick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Catherine Jefferys</b> Address <b>Cumberland, Md</b> <b>149 Polk St.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>----</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/14/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park,</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 17 '60</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

108936

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10893

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>50 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>436 Park Street</b>				d. STREET ADDRESS <b>436 Park Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Asbury</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 11 1884</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>		IF UNDER 24 HRS. <b>76</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Levels, West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph E. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Largent</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-10-6447A</b>		17. INFORMANT Address <b>Mrs. Catherine Gall, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Cervical Cancer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Seminal prostatectomy</b> (b) <b>Prostatectomy</b> DUE TO <b>Prostatectomy</b> (c) <b>Prostatectomy</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 15</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct 15</b> 19 <b>60</b> , and that death occurred at <b>10:59 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>B. M. Schindler</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/22/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. M. SCHINDLER</b>				22d. ADDRESS <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>OCT. 24, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 25 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

10893

CERTIFICATE OF BIRTH

10893





## CERTIFICATE OF DEATH

Reg. Dist. No. 10894

10897

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>40 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1214 Lafayette Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Snyder</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ice &amp; Fuel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Lockhaven, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Drell Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Alice Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-7163</b>	
17. INFORMANT <b>Mrs. Joseph Snyder, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>General Arteriosclerosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic old Rt foot 2 yrs ago</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>10 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>9/11</b> , 19 <b>60</b> to <b>10/23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Sept</b> , 19 <b>60</b> , and that death occurred at <b>11:20</b> M., from the causes and on the date stated above. <b>10/23/60</b> ADDRESS (Street, city or town, state) <b>59 GREENE ST</b> DATE SIGNED <b>10/25/60</b>			
ACTUAL SIGNATURE <b>S. G. WEISMAN</b> M.D.		PHYSICIAN'S NAME (Type) <b>S. G. WEISMAN MD</b> <b>CUMBERLAND, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-26-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Abe Cemetery</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Ridgeley, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 31 '60</b>	
24b. REGISTRAR'S SIGNATURE <i>Clifford J. Howard</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10887

CERTIFICATE OF DEATH

10887

DECEASED

DECEASED

1

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. WILSON		M		45		JAN 15 1900		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 MAIN ST. NEW YORK		CLOCK REPAIRER		HEART DISEASE		NATURAL		NEW YORK	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 15 1945		10:30 AM		10		30		00	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERK	
DATE OF REGISTRATION		TIME OF REGISTRATION		HOUR OF REGISTRATION		MINUTE OF REGISTRATION		SECOND OF REGISTRATION	
JAN 15 1945		10:30 AM		10		30		00	

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M  
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10945

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10895

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - FROSTBURG</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X FROSTBURG - RURAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>B.</b> Last <b>KALLMYER</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 20, 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES SOMMERKAMP</b>				14. MOTHER'S MAIDEN NAME <b>EMMA SNYDER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <b>214-01-3768A</b>			
17. INFORMANT <b>HAROLD KALLMYER, FROSTBURG, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 7-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO years (c) INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1950</b> to <b>Oct 3 1960</b> that (I) <del>last</del> saw the deceased alive on <b>Oct. 3 1960</b> and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John B. Davis,</b>				22b. ADDRESS <b>BROADWAY, FROSTBURG, MD.</b>		22c. DATE SIGNED <b>10/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M. D.</b>				22d. ADDRESS <b>BROADWAY, FROSTBURG, MD.</b>		22e. DATE <b>10/7/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10-8-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ECKHART, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. P. Hurst</b>				25a. REC'D BY REGISTRAR <b>DATE OCT 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur D. Hurst</b>	

10835

CENTRAL AT THE DEATH

10835

Handwritten notes and signatures, including "John B. Brown" and "J. B. Brown".

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. For a burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10897

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARRELSVILLE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Pearl</u> Last <u>KELLY</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1960</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 1905</u>			
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
13. FATHER'S NAME <u>CHRISTOPHER O' BAKER</u>				14. MOTHER'S MAIDEN NAME <u>ELLA MC CRAY</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>SON Leonard E Kelly MD Surgeon</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>  </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Benedict Skitarelis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIS, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>OCTOBER 8, 1960</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stem, Inc. Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>			



02805



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10899 CERTIFICATE OF DEATH 10898

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>1 208 N CENTER STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TIMOTHY</u> Middle <u>L.</u> Last <u>KENNY</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/10/77</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Truck Worker Mt Savage, Maryland</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>			
13. FATHER'S NAME <u>EDWARD KENNY</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN KENNY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>CHART</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>60</u> , to <u>10/27</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> , 19 <u>60</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo H. Levy</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/28/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. L. H. LEVY</u>				22d. ADDRESS <u>456 N CENTER STREET</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/31/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Patrick's Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Mt Savage Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>				ADDRESS <u>Cumbr. Md</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 31 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

19450-40 314117-7

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10899

10900

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>9 Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOTTIE</b> Middle <b>May</b> Last <b>Kifer</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 7th, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Polish Mt. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH MCCOY</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Marion Nesselrodt, Rt. #1 Flintstone</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart disease</b> DUE TO <b>260x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>diabetes mellitus</b> DUE TO (c) <b>generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral opathy (stroke 5 yrs. ago) hemiplegia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1952</b> to <b>10/28</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>10/28</b> 19 <b>60</b> , and that death occurred at <b>8 P.</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Elizabeth Brings</b>		22b. DATE SIGNED <b>10/29/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. ELIZABETH BRINGS.</b>		22d. ADDRESS <b>55 Greene St. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/31/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prosperity Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Nr. Chaneyville, Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 1 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

109001

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10900

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>10/2/60</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				e. STREET ADDRESS <b>Along Rt. # 51</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Selvester</b> Last <b>Kline</b>				4. DATE OF DEATH Month <b>October</b> Day <b>11</b> , Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/17/1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>Joseph Kline</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>				16. SOCIAL SECURITY NO. <b>No.</b>		17. INFORMANT <b>P.O.Box 599,</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardial Degeneration</b> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Chronic nephritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Spontaneous Hemorrhage</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/2/60</b> to <b>10/11/60</b> , that (I) (we) last saw the deceased alive on <b>10/11/60</b> at <b>5:55 P.M.</b> and that death occurred at <b>10/11/60</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James E. McLean</b>				22b. DATE SIGNED <b>10/12/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>	
22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				25a. REC'D BY REGISTRAR <b>OCT 17 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

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CERTIFICATE OF DEATH

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Allegany

Allegany

Allegany

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10/2/60

Allegany

Allegany County Jail

Harvey Belvester Mine October 15, 1960

White White 9/27/1879

West Virginia 7. 2. 4.

Joseph Kline Catherine Smith

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail

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Allegany County Jail

10/1/60 10/1/60

10/1/60 10/1/60

Dr. James E. McLean 19 Greene St., Cumberland, Md.

10/1/60 10/1/60

10/1/60 10/1/60



**DEPUTY FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it may be returned by the hospital or attending physician. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

10902

10901

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>138 BEDFORD ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>TENNIE</b> Middle <b>C</b> Last <b>KLINE</b>		4. DATE OF DEATH Month <b>OCT.</b> Day <b>27</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 20 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>WILLIAM YOST (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE Hobday</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>PATIENTS CHART.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> 19 <b>60</b> to <b>10/27</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>10/27</b> 19 <b>60</b> , and that death occurred at <b>2:30 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Leo H. Ley, Jr.</b>		22b. DATE SIGNED <b>10/28/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEO H. LEY, JR., M.D.</b>		22d. ADDRESS <b>456 N. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/30/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 31 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

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CERTIFICATE OF DEATH

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THE DEATH OF A PERSON WHOSE NAME IS GIVEN IN THE FIRST COLUMN OF THIS FORM

AND THE CAUSE OF DEATH IS GIVEN IN THE SECOND COLUMN OF THIS FORM

AND THE DATE OF DEATH IS GIVEN IN THE THIRD COLUMN OF THIS FORM

AND THE PLACE OF DEATH IS GIVEN IN THE FOURTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHOSE DEATH IS REPORTED IS GIVEN IN THE FIFTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO REPORTS THE DEATH IS GIVEN IN THE SIXTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE SEVENTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE EIGHTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE NINTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE TENTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE ELEVENTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE TWELFTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE THIRTEENTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE FOURTEENTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE FIFTEENTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE SIXTEENTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE SEVENTEENTH COLUMN OF THIS FORM

AND THE NAME OF THE PERSON WHO SIGNIFIES THE DEATH IS GIVEN IN THE EIGHTEENTH COLUMN OF THIS FORM

Reg. Dist. No. 10902

10903

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>135 Bedford St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Anna Margaret Knieriem</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>October 27 1960</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Jan 22, 1900</b>
<b>9. AGE</b> (In years last birthday) yrs. <b>60</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Cumberland, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Gustave Knieriem</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Edith M. Myers</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>  <b>17. INFORMANT</b> Address <b>Gustave Knieriem Cumberland, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA, CARDIAC DECOMPENSATION</b> DUE TO (b) <b>CHRONIC MYOCARDITIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m.  <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  	<b>20f. (City or town)</b> (County) (State)  
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>, Inspection</b> <input checked="" type="checkbox"/> <b>, Inquiry</b> <input checked="" type="checkbox"/> <b>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> <b>, Accident</b> <input type="checkbox"/> <b>, Suicide</b> <input type="checkbox"/> <b>, Homicide</b> <input type="checkbox"/> <b>, Undetermined cause</b> <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <i>Benedict Skitarelic</i> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <b>BENEDICT SKITARELIC, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>October 27, 1960</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>Oct. 31, 1960</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Luke's Cemetery</b>	<b>22d. LOCATION (City, town, or county)</b> (State) <b>Cumberland, Maryland</b>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Louis Sturdivant</i>		<b>ADDRESS</b> <b>117 Frederick St. Cumb. Md.</b>	
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>OCT 31 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>	

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10203

10203

NAME OF DECEASED		SEX		AGE	
JAMES H. HARRIS		Male		45	
RESIDENCE		OCCUPATION		CAUSE OF DEATH	
1234 Main St., Baltimore, Md.		Carpenter		Myocardial Infarction	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
October 15, 1950		Home		Natural	
TIME OF DEATH		HOURS		MINUTES	
10:30 AM		10		30	
TEMPERATURE		PULSE		BLOOD PRESSURE	
98.6		72		120/80	
WEIGHT		HEIGHT		HAIR	
175 lbs.		5' 10"		Brown	
EYES		TEETH		SKIN	
Blue		Dentures		Fair	
TONGUE		THROAT		LUNGS	
Pink		Clear		Emphysematous	
HEART		LIVER		SPLEEN	
Enlarged		Normal		Normal	
KIDNEYS		PANCREAS		INTESTINES	
Normal		Normal		Normal	
BLADDER		PROSTATE		VAGINA	
Normal		Enlarged		Normal	
UTERUS		OVARIES		TUBES	
Normal		Normal		Normal	
CERVIX		VAGINA		TUBES	
Normal		Normal		Normal	
LABIA		CLITORIS		PENIS	
Normal		Normal		Normal	
SCROTUM		TESTES		EPIDIDYMIS	
Normal		Normal		Normal	
VASCULATURE		LYMPHATIC		NERVOUS	
Normal		Normal		Normal	
MUSCULATURE		BONES		JOINTS	
Normal		Normal		Normal	
SKULL		BRAIN		SPINAL CORD	
Normal		Normal		Normal	
VERTEBRAL COLUMN		RIBS		STERNUM	
Normal		Normal		Normal	
PELVIS		FEMURS		HUMERI	
Normal		Normal		Normal	
ULNAE		CARPALS		METACARPALS	
Normal		Normal		Normal	
PHALANXES		TOES		FINGERS	
Normal		Normal		Normal	
NAILS		HAIR		SCALP	
Normal		Normal		Normal	
EARS		NOSE		MOUTH	
Normal		Normal		Normal	
PHARYNX		ESOPHAGUS		STOMACH	
Normal		Normal		Normal	
DUODENUM		JEJUNUM		ILEUM	
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CECUM		SIGMOID		RECTUM	
Normal		Normal		Normal	
ANUS		VAGINA		TUBES	
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Normal		Normal		Normal	
LABIA		CLITORIS		PENIS	
Normal					

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VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10946

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10903

1. PLACE OF DEATH a. COUNTY <u>Alleghany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rawlings</u>		c. LENGTH OF STAY IN 1b <u>3 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Star Route Oakland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>11X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nathaniel DANIEL</u> First Middle Last				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>7</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 5, 1919</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathaniel Knox</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Knox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes (unk.)</u>		17. INFORMANT Address <u>Mrs. Paul Friend Swanton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency (ACUTE FAILURE)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> (c) <u>Also terminal aspiration of stomach contents.....</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-4-minutes</u> ***---	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>OCTOBER 10, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thayerville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrett Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spald N. Minnich</u>				ADDRESS <u>Oakland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

DATE SIGNED





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND, STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																		
10934					CERTIFICATE OF DEATH					Reg. Dist. No. 10904								
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>					c. LENGTH OF STAY IN 1b <b>10 years</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>126 Hill Street</b>					d. STREET ADDRESS <b>126 Hill Street</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ALICE</b> Last <b>KREITZBURG</b>					4. DATE OF DEATH Month <b>10</b> Day <b>1</b> Year <b>19 60.</b>													
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-9-1877</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Eckhart</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>								
13. FATHER'S NAME <b>Morris Townsen Porter</b>					14. MOTHER'S MAIDEN NAME <b>Mary Ann Rephann</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>					16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mrs. Albert Miller, 126 Hill St.,</b>			Address <b>Frostburg</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>years</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>50</b> , to <b>Oct-1</b> , 19 <b>60</b> that I last saw the deceased alive on <b>October 1</b> , 19 <b>60</b> , and that death occurred at <b>10 A M</b> , from the causes and on the date stated above.																		
ACTUAL SIGNATURE <b>John B. Davis</b> , M.D.					ADDRESS (Street, city or town, state) <b>2 BROADWAY</b>					DATE SIGNED <b>10/4/60</b>								
PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D. Frostburg, Md.</b>																		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>10-4-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Eckhart Md.</b>								
23. FUNERAL DIRECTOR'S SIGNATURE <b>Beverly H. Montemar</b>					24a. REC'D BY REGISTRAR <b>23 East Main, Frostburg, Md.</b>					DATE <b>OCT 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneiss</b>						

5601



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10904

Reg. Dist. No.

10905

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1 Hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>235 Independence Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jessie May Langford</b>				4. DATE OF DEATH Month Day Year <b>October 7 19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1902</b>		9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Roby</b>				14. MOTHER'S MAIDEN NAME <b>Marie Layton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>C. C. Roby 403 Linden St, Cumberland, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1-2 Hrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>OCTOBER 7, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/10/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reckley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pickard Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b>				ADDRESS <b>Cumberland Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 10 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
10905 CERTIFICATE OF DEATH 10906											
1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. SAVAGE RT. #1</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>						d. STREET ADDRESS <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORNELIUS</u> Middle <u>W</u> Last <u>LEONARD</u>						4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>19 60</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8/17/17</u>		9. AGE (In years lost birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Yard</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE LEONARD</u>						14. MOTHER'S MAIDEN NAME <u>ANNIE RINGER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>175-16-8942</u>		17. INFORMANT <u>CHART</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>10 - 21</u> <u>1960</u> to <u>10 - 27</u> <u>1960</u> , that (I) (we) lost the deceased alive on <u>10 - 27</u> <u>1960</u> , and that death occurred at <u>2</u> p.m., from the causes and on the date stated above.											
22a. SIGNATURE <u>Rae, R. W. Ballin</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. R.W. BALLIN</u>						22d. ADDRESS <u>62 GREENE STREET</u> <u>10-28-60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/31/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Silbaugh Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>R.D. Confluence, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Humbert</u>						ADDRESS <u>Confluence, Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 31 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		b. COUNTY	
ALLEGANY				MARYLAND		ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				d. STREET ADDRESS 9 ASBURY AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First RUTH		Middle A.		Last LIVENGOOD	
4. DATE OF DEATH		Month OCTOBER		Day 27		Year 19 60	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-28-1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
3. FATHER'S NAME MATTHEW JONES				14. MOTHER'S MAIDEN NAME Mary Hetrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary embolism</u> DUE TO 584X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>suppurative disease of gallbladder</u> DUE TO (c) <u>cholelithiasis</u>						INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>60</u> , to <u>10-27</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>10-27</u> , 19 <u>60</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>L. Brings</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. L. BRINGS				22d. ADDRESS 57 Green St. Cumberland Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/29/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE OCT 31 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10301

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director may be retained by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10907

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10908

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA PA.</b> b. COUNTY <b>HYNDMAN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL AVE.</b>				d. STREET ADDRESS <b>75X-3</b>	
3. NAME OF DECEASED (Type or print) <b>BABY</b>		First <b>BOY (A)</b>		Last <b>MAY</b>	
4. DATE OF DEATH Month <b>OCTOBER</b>		Day <b>5</b>		Year <b>19 60</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>OCTOBER 3, 1960</b>		9. AGE (In years lost birthday) yrs. <b>1</b>		10. IF UNDER 1 YEAR Months <b>1</b>	
11. IF UNDER 24 HRS. Days <b>20</b>		12. IF UNDER 24 HRS. Hours <b>8</b>		13. IF UNDER 24 HRS. Min. <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>ROSS A. MAY</b>		14. MOTHER'S MAIDEN NAME <b>BETTY JEAN FRANKS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency due To</b> <b>754-4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Endocardial Fibro-Elastosis</b> DUE TO (c) <b>2 days</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>500X</b>		20g. (County) <b>60</b>		20h. (State) <b>500X</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>30 Oct</b> to <b>5 Oct</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>5 Oct</b> , 19 <b>60</b> , and that death occurred at <b>7:20 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Leland Ransom</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5 Oct 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. LELAND RANSOM</b>		22d. ADDRESS <b>1002 Holland St., 63 Greene St.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 6, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Hyndman, Pa. Bedford Co.</b>		23e. (State) <b>Pa.</b>		23f. (County) <b>Bedford Co.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Leigler</b>		ADDRESS <b>Hyndman, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 10 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25c. (City, town, or county) <b>Hyndman, Pa.</b>			

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may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10935  
10909  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MINERS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PATRICK</b> Middle <b>J.</b> Last <b>McGUIRE</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>2</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 29, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINES</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PATRICK McGUIRE</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE DRISCOLL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT Address <b>MRS. PATRICK McGUIRE, FROSTBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420-0</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 20, 19 60</b> to <b>Oct 2, 19 60</b> that (I) (we) last saw the deceased alive on <b>Oct 2, 19 60</b> and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John B. Davis, M.D.</b>		22b. DATE SIGNED <b>10/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M. D.</b>		22d. ADDRESS <b>BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10-5-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. P. Burt</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 4 '60</b>	
ADDRESS <b>FROSTBURG, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

10001





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in, and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10908

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10910

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>29 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>N</b> Last <b>MONAHAN</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/1/01</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>PATRICK MONAHAN</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE MULLEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-05-9675</b>			
17. INFORMANT <b>Mrs. Agnes Monahan, Midland, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>154X</b> IMMEDIATE CAUSE (a) <b>cover of the heart</b> DUE TO (b) <b>cover of the heart</b> DUE TO (c) <b>cover of the heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>154X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2-4-</b> 19 <b>59</b> to <b>10-6-</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>10-6-</b> 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Brings</b>				22b. DATE SIGNED <b>10-6-1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. L. BRINGS</b>				22d. ADDRESS <b>57 GREENE STREET</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/10/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>				25a. REC'D BY REGISTRAR <b>LONACONING? MD.</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>				25c. DATE <b>OCT 11 '60</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10947

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10911

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland (Rural)</u>			c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural, near Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 3 Valley Road</u>				d. STREET ADDRESS <u>Route 3, Valley Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>EDNA</u> First <u>PEARL</u> Middle <u>MOORE</u> Last				<b>4. DATE OF DEATH</b> <u>October 17</u> 19 <u>60</u> Month Day Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 17, 1897</u>		
9. AGE (In years lost birthday) yrs. <u>62</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Carlos, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Griffith Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Rt. 3. Valley Road</u> <u>Emory M. Moore, Cumberland, Maryland</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis with Deformation</u> DUE TO <u>4-22-2</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10-10-1960</u> to <u>10-17-1960</u> that (I) (we) last saw the deceased alive on <u>10-10-1960</u> and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.								
22a. SIGNATURE <u>James T. Johnson, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct. 18, 1960</u>		
22c. PHYSICIAN'S NAME (Type) <u>James T. Johnson, Jr.</u>				22d. ADDRESS <u>16 Greene Street, Cumberland, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>		
						25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>		

10817

10817

CHIEF OF DEATH

CHIEF OF DEATH

CHIEF OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

10909

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>410 Fayette St.</b>				d. STREET ADDRESS <b>410 Fayette St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Somerville</b> Middle <b>Nicholson</b> Last				4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1897</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assessment Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Allegany County</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Augustus S. Nicholson</b>				14. MOTHER'S MAIDEN NAME <b>Linny Bell Wilking</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.1</b>		17. INFORMANT <b>Somerville Nicholson Jr., Alexandria, Virginia</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION, LEFT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SCLEROSIS WITH THROMBOSIS</b> DUE TO (c) <b>SUDDEN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Hypertrophy, marked</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>OCTOBER 31, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 2, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>117 Frederick St. Cumb. Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>	





## CERTIFICATE OF DEATH

10913

Reg. Dist. No.

10948

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. #1, Box 38, (New Shaft)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AUSBEE</b> Middle <b>S.</b> Last <b>PLUMMER</b>		4. DATE OF DEATH Month <b>10</b> Day <b>9</b> Year <b>19 60.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-1892</b>
9. AGE (In years lost birthday) <b>68 yrs.</b>		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.	11. IF UNDER 24 HRS. Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Shaft, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David H. Plummer</b>		14. MOTHER'S MAIDEN NAME <b>Carolina Seaton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-0776</b>	
17. ADDRESS <b>Frostburg, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Failure</b> 443X DUE TO <b>HCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>24hrs</b> (c) <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>53</b> to <b>Sept</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Sept</b> , 19 <b>60</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>10/11/60</b>	
ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>		PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D. Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-12-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Montague</b>		24a. REC'D BY REGISTRAR <b>Oct 14 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		24c. ADDRESS <b>23 E. Main, Frostburg, Md.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10910  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10914

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8/19/1960</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		d. STREET ADDRESS <b>202 Grand Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>D.</b> Last <b>Poland</b>		4. DATE OF DEATH Month <b>October</b> Day <b>21</b> , Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/23/1883</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Daniel M. Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Mary Carlile</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O.Box 599,</b> <b>Allegany County Infirmary Records</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Sclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocardial Degeneration</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/19/60</b> 19 to <b>10/21/60</b> 19, that (I) (we) last saw the deceased alive on <b>10/20/60</b> 19, and that death occurred at <b>1:10 A.M.</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>James E. McLean</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>10/21/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-23-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Babtist Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Three Churches, W.Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 26 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Q691: 55/3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10949  
CERTIFICATE OF DEATH

10915

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		c. LENGTH OF STAY IN 1b <b>86 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1 Mi. E. Barton</b>		d. STREET ADDRESS <b>1 Mi. E. Barton</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Amy Ellen Preston</b>		4. DATE OF DEATH <b>Oct. 29 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1874</b>
9. AGE (In years lost birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Metz</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Poland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Charles Ross-Rawlings, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Hours</b> <b>5 Years</b> <b>5 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 10 1960</b> to <b>Oct. 29 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct. 29 1960</b> , and that death occurred at <b>5:15 A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul R. Wilson</b>		22b. DATE SIGNED <b>Oct. 29, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>		22d. ADDRESS <b>Piedmont, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/31/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Moscow, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boal</b>		ADDRESS <b>Westernport, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 2 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10916

Reg. Dist. No.

10911

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>LaVale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>233 Beall St.</u>				d. STREET ADDRESS <u>552 Braddock Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOHN</u> First <u>EMMETT</u> Middle <u>RESLEY</u> Last				<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>2</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>June 16, 1896</u>		<b>9. AGE</b> (In years last birthday) <u>64</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electrical foreman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Kelly Tire Co.</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Cumberland, Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>John B. Resley</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Isora Murray</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>W. W. I</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>214-07-0284</u>		<b>17. INFORMANT</b> <u>Mrs. Leona Zink</u> Address <u>233 Beall St. Cumb. Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420-1</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitarelic</u> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>BENEDICT SKITARELIC, M.D.</u>				<b>DATE SIGNED</b> <u>OCTOBER 2, 1960</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Oct. 5, 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Burial Park</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Cumberland, Md.</u> (State) <u>  </u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. Wayne George, Cumberland, Md.</u>					
<b>24a. REC'D BY REGISTRAR</b> <u>OCT 5 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

1109

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10917**

**10912**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hosp.</b>		d. STREET ADDRESS <b>Willowbrook Road,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VERDIE</b> Middle <b>MAY</b> Last <b>RICE</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>27,</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1874</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b>	IF UNDER 24 HRS. Hours <b>86</b> Min. <b>86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Twigg town, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hanson Twigg</b>		14. MOTHER'S MAIDEN NAME <b>Martha Hite</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Lillian V. Miller</b>		Address <b>Cumb. Md. Willowbrook Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYOCARDITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>-----</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURE OF LEFT HIP</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL IN KITCHEN OF OWN HOME</b>	
20c. TIME OF INJURY Hour <b>5:30</b> p. m. <b>Oct. 22</b> 19 <b>60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Rt. #4 Cumberland, alleg, md</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/29/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park, Cumberland, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the "Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10913

CERTIFICATE OF DEATH

Reg. Dist. No.

10918

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>326 Beall St.,</b>				d. STREET ADDRESS <b>1 326 Beall St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>JOHN</b> Last <b>ROBERTSON</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>31,</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 5, 1898</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David Robertson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes,</b>		16. SOCIAL SECURITY NO. <b>W.W. # 1 216-07-2689</b>		17. INFORMANT <b>Mrs. Mary Robertson 326 Beall St., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerosis obliterans</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>11 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/13</b> , 19 <b>60</b> , to <b>10/31</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/24</b> , 19 <b>60</b> , and that death occurred at <b>3:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing St.,</b> DATE SIGNED <b>11/2/60</b>							
ACTUAL SIGNATURE <b>Samuel M. Jacobson</b>				M.D. <b>50 Pershing St.,</b>			
PHYSICIAN'S NAME (Type) <b>Samuel M. Jacobson M.D.</b>				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park,</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>			

NOV 4 '60



3228





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 10919										
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Rt #5</b>			c. LENGTH OF STAY IN 1b <b>6 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Rt #5</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box #311</b>					d. STREET ADDRESS <b>Box #311</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Stewart</b> Last <b>Rodeheaver</b>					4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>19 60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 23, 1925</b>		9. AGE (In years last birthday) <b>35</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Used car dealer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles S. Rodeheaver</b>					14. MOTHER'S MAIDEN NAME <b>Minnie E. Teets</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-14-6814</b>		17. INFORMANT <b>Mrs. JoAnn Rodeheaver</b>			Address <b>468 Columbia St, Cumberland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SKULL FRACTURE, CEREBRAL MACERATION, HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gunshot wound of head</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>5-10 Min.</b>  <b>11</b>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>4:00</b> a. m. <b>22</b> Oct. <b>1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Rt. 5 Cumberland, Alleg. Md.</b>		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Benedict Skitarulic</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>BENEDICT SKITARULIC, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>OCTOBER 22, 1960</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/24/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b>					ADDRESS <b>Cumberland Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 26 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10914 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10920

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> <b>02</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>807 Mann's Terrace</b>		d. STREET ADDRESS <b>807 Mann's Terrace</b> <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lola</b> Middle <b>Belle</b> Last <b>Rogers</b>		4. DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1897</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b>	IF UNDER 24 HRS. Hours <b>63</b> Min. <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile worker,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Berkley Springs, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David R. Henry</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Cross</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>216-14-1341</b>	
17. INFORMANT <b>Mr. Carl F. Rogers</b>		Address <b>Cumb. Md. 807 Mann's Terrace</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.M</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>OCTOBER 4, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/6/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10921

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>4/30/52</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		d. STREET ADDRESS <b>318 Beall Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>F.</b> Last <b>Rossworm</b>		4. DATE OF DEATH Month <b>October</b> Day <b>26,</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/29/1890</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Florist Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Florist</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Vitus R. Rossworm</b>		14. MOTHER'S MAIDEN NAME <b>Susan Brodigan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O.Box 599,</b> Address <b>Cumberland, Md.</b>		<b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> DUE TO <b>592x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Bronchial Asthma</b> DUE TO <b>Chronic Nephritis</b> (c) <b>Osteoporosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoporosis</b>			
INTERVAL BETWEEN ONSET AND DEATH ? ? ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/30/52</b> , 19____, to <b>10/26/60</b> , 19____, that (I) (we) lost saw the deceased alive on <b>10/25/60</b> , 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. McLean</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>10/26/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b> 22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/28/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul's</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
25a. REC'D BY REGISTRAR <b>OCT 31 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraw</b>	



10322

CENTRAL OF DEATH

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10918

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10922

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>40 MIN.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRIETTA</b> Middle <b>SCHWARZENBACH</b> Last <b>SCHWARZENBACH</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 16, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Partner in business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Men's Clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE SCHWARZENBACH</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET Wiegman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-34-1210</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO (b) <b>2-17-60</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-17-60</b> to <b>10-11-60</b> that (I) (we) last saw the deceased alive on <b>10-11-60</b> and that death occurred at <b>10:10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W.F. Williams</b>		22b. DATE SIGNED <b>10-13-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLIAMS</b>		22d. ADDRESS <b>Cumberland Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 14, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		25a. REC'D BY REGISTRAR <b>OCT 17 '60</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10032

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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Item 11 Film 6274 11-3-60 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>58yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> <b>02</b>		d. STREET ADDRESS <b>422 Grand Ave</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>422 Grand Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Peter</b> Middle <b>Schwenninger</b> Last <b></b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 4, 1883</b>
9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Hardware Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Luxembourg</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nicholas Schwenninger</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Haan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Paul Schwenninger</b>		Address <b>107 South St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Thrombosis</b> DUE TO <b>Bronchial Asthma</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>10 yrs</b> <b>12 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>50</b> , to <b>Oct. 31, 1960</b> , that I last saw the deceased alive on <b>Oct. 25, 1960</b> , and that death occurred at <b>9:15P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		DATE SIGNED <b>11/1/60</b>	
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett 236 Virginia Ave. Cumberland, Md.</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-3-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SS Peter &amp; Paul Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

# CERTIFICATE OF DEATH

1119

1

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>	
<p>15. SIGNATURE OF JUDGE</p>		<p>16. SIGNATURE OF CLERK</p>	



2501



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10938

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10925

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. LENGTH OF STAY IN 1b <u>43</u> yrs. <u>43</u> <u>Westernport</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 Rock St.</u>		d. STREET ADDRESS <u>1 207 Rock St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Privella</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1868</u>
9. AGE (In years lost birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jefferson Fagenbaker</u>		14. MOTHER'S MAIDEN NAME <u>Mary Michael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. William McGee</u> Address <u>Westernport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4-22-01</u> IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>10 Years</u> DUE TO (c) <u>5 Years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u> <u>10 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 12, 1960</u> to <u>Oct 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 15, 1960</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul R. Wilson</u> M.D.		22b. DATE <u>Oct 17, 1960</u> SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u>		22d. ADDRESS <u>Piedmont, W.Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 18, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Westernport, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. Boal</u> ADDRESS <u>Westernport, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 20 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

10938

CERTIFICATE OF DEATH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

10938

*[Faint, mostly illegible text from the reverse side of the document, including what appears to be a signature and various fields.]*

may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10918

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10926

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>10/5/60</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>R.</b> Last <b>Struntz</b>		4. DATE OF DEATH Month <b>October</b> Day <b>24</b> , Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/1864</b>
9. AGE (In years lost birthday) <b>96</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Tanzer</b>		14. MOTHER'S MAIDEN NAME <b>Born in Austria - Family Records lost - can't obtain name.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O. Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hypostasis</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Chronic Myocardial Degeneration</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Smile Detention</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/5/60</b> 19 to <b>10/24/60</b> 19, that (I) (we) last saw the deceased alive on <b>10/24/60</b> 19, and that death occurred at <b>5:42 P.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. McLean</b> M.D.		22b. DATE SIGNED <b>10/25/1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-27-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montesant</b>		25. REC'D BY REGISTRAR <b>Hafer Funeral Home</b> <b>23 E. Main, Frostburg, Md.</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

(M)

(I)

(O)

bp

81601-100

4001615

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

10919

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> 02		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Robert St. W. Md. Railroad Crossing</u>				d. STREET ADDRESS <u>II9 Robert St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Leroy</u> Last <u>Swanger</u>				4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 19, 1959</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Joyce Marie Swanger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Joyce M. Swanger II9 Robert St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Struck by railroad train</u> DUE TO (c) <u>"</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by train</u>					
20c. TIME OF INJURY Month, Day, Year <u>5:15</u> Hour <u>pm</u> <u>Oct. 7</u> 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Near Robert St. Cumberland, Alleg. Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarellic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Oct. 7, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oliver Grove Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Near Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. SIGNATURE OF EXAMINER		10. SIGNATURE OF WITNESS		11. SIGNATURE OF CORONER		12. SIGNATURE OF JURY	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF PRIEST		16. SIGNATURE OF MINISTER	
17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME		19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CREMATOR	
21. SIGNATURE OF CEMETERY		22. SIGNATURE OF INTERMENT		23. SIGNATURE OF BURIAL		24. SIGNATURE OF CREMATION	
25. SIGNATURE OF EXHIBIT		26. SIGNATURE OF RECORD		27. SIGNATURE OF INDEX		28. SIGNATURE OF FILE	
29. SIGNATURE OF COPY		30. SIGNATURE OF RETURN		31. SIGNATURE OF FILING		32. SIGNATURE OF DEPOSIT	
33. SIGNATURE OF DEPOSIT		34. SIGNATURE OF RETURN		35. SIGNATURE OF FILING		36. SIGNATURE OF DEPOSIT	
37. SIGNATURE OF RETURN		38. SIGNATURE OF FILING		39. SIGNATURE OF DEPOSIT		40. SIGNATURE OF RETURN	
41. SIGNATURE OF FILING		42. SIGNATURE OF DEPOSIT		43. SIGNATURE OF RETURN		44. SIGNATURE OF FILING	
45. SIGNATURE OF DEPOSIT		46. SIGNATURE OF RETURN		47. SIGNATURE OF FILING		48. SIGNATURE OF DEPOSIT	
49. SIGNATURE OF RETURN		50. SIGNATURE OF FILING		51. SIGNATURE OF DEPOSIT		52. SIGNATURE OF RETURN	
53. SIGNATURE OF FILING		54. SIGNATURE OF DEPOSIT		55. SIGNATURE OF RETURN		56. SIGNATURE OF FILING	
57. SIGNATURE OF DEPOSIT		58. SIGNATURE OF RETURN		59. SIGNATURE OF FILING		60. SIGNATURE OF DEPOSIT	
61. SIGNATURE OF RETURN		62. SIGNATURE OF FILING		63. SIGNATURE OF DEPOSIT		64. SIGNATURE OF RETURN	
65. SIGNATURE OF FILING		66. SIGNATURE OF DEPOSIT		67. SIGNATURE OF RETURN		68. SIGNATURE OF FILING	
69. SIGNATURE OF DEPOSIT		70. SIGNATURE OF RETURN		71. SIGNATURE OF FILING		72. SIGNATURE OF DEPOSIT	
73. SIGNATURE OF RETURN		74. SIGNATURE OF FILING		75. SIGNATURE OF DEPOSIT		76. SIGNATURE OF RETURN	
77. SIGNATURE OF FILING		78. SIGNATURE OF DEPOSIT		79. SIGNATURE OF RETURN		80. SIGNATURE OF FILING	
81. SIGNATURE OF DEPOSIT		82. SIGNATURE OF RETURN		83. SIGNATURE OF FILING		84. SIGNATURE OF DEPOSIT	
85. SIGNATURE OF RETURN		86. SIGNATURE OF FILING		87. SIGNATURE OF DEPOSIT		88. SIGNATURE OF RETURN	
89. SIGNATURE OF FILING		90. SIGNATURE OF DEPOSIT		91. SIGNATURE OF RETURN		92. SIGNATURE OF FILING	
93. SIGNATURE OF DEPOSIT		94. SIGNATURE OF RETURN		95. SIGNATURE OF FILING		96. SIGNATURE OF DEPOSIT	
97. SIGNATURE OF RETURN		98. SIGNATURE OF FILING		99. SIGNATURE OF DEPOSIT		100. SIGNATURE OF RETURN	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person authorized by the State Board of Health prior to burial, cremation, or removal, in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Board of Health.

Item 18 Film 273 10-1-1960									
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
10920 CERTIFICATE OF DEATH 10928									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>4 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			d. STREET ADDRESS <b>223 BALTIMORE ST.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>F.</b> Last <b>TWIGG</b>					4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>6</b> Year <b>1960</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-16-1884</b>		9. AGE (In years lost birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transfer Business</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Francis T. Twigg</b>					14. MOTHER'S MAIDEN NAME <b>Alice Kifer</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-3368</b>		17. INFORMANT <b>CHART</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>generalized arteriosclerosis</b> Cerebral hemorrhage (b) <b>Generalized arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10-6-60</b> to <b>10-7-60</b> , that (I) (we) last saw the deceased alive on <b>10-6-60</b> and that death occurred on <b>10-7-60</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>F. J. Johnson Jr</b> 22a. PHYSICIAN'S NAME (Type) <b>DR. J. T. JOHNSON Jr</b>					22b. DATE SIGNED <b>10-7-60</b> 22b. ADDRESS <b>16 Greene St, Cumberland Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b> <b>Cumberland Maryland</b>					25a. REC'D BY REGISTRAR DATE <b>OCT 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

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2006-2007

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial-transit permit, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10929**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>12 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sylvan Retreat</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>WALKENSHAW</b> Last				4. DATE OF DEATH Month <b>10</b> Day <b>10</b> Year <b>19 60</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-4-1895</b>		9. AGE (In years last birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Midland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Walkenshaw</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Barber</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-20-5633</b>		17. INFORMANT <b>Mrs. Andrew Taylor, 6214 Kilmer St.,</b> Address <b>Cheverly, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS, LEFT</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>420</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 Hr.</b> <b>---</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>OCTOBER 10, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-13-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eckhart Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bulah H. Whiteside</b> ADDRESS <b>23 E. Main, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	



Reg. Dist. No. 10930

~~10922~~

Reg. Dist. No. 10930

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN Ib <b>48yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>III6 Kentucky Ave</b>				d. STREET ADDRESS <b>III6 Kentucky Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles H. Weaver</b>		First Middle Last		4. DATE OF DEATH <b>IO-I6-60</b>		Month Day Year <b>19</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 19, 1881</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Pottstown, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry S. Weaver</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Lachman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-07-7014</b>		17. INFORMANT <b>Naomi E. Weaver</b> Address <b>III6 Kentucky Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Right Cerebral Hemorrhage with</b> DUE TO (c) <b>Left Hemiplegia</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 day</b> <b>7 day</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 1958</b> to <b>Oct 16, 1960</b> , that I last saw the deceased alive on <b>Oct. 16, 1960</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>236 Va. Ave. Cumberland Md</b> DATE SIGNED <b>1960</b>							
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		M.D. <b>236 Va. Ave. Cumberland Md</b>					
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett 236 Virginia Ave. Cumberland Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>IOI8-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 19 60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clayton E. Hester</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_ may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										10931	
10923										CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>						
b. CITY OR TOWN (If outside corporate limits, write <b>RURAL</b> and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write <b>RURAL</b> and give nearest town) <b>OLDTOWN</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>					d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMORY</b> Middle <b>J. WIGFIELD,</b> Last			4. DATE OF DEATH Month <b>OCT. 16</b> Day <b>19</b> Year <b>60</b>								
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/5/76</b>		9. AGE (In years last birthday) <b>84</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>		11. BIRTHPLACE (State or foreign country) <b>TOWN CREEK, MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>JOHN WIGFIELD</b>				14. MOTHER'S MAIDEN NAME <b>DEBRA SHRYOCK</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-54-3579</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vasculat renal disease</b> DUE TO (c) <b>?</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from <b>10.5.1960</b> to <b>10.16.1960</b> that (I) (we) last saw the deceased alive on <b>10.16.1960</b> and that death occurred at <b>1:00PM</b> from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE <b>Dr. W.F. Williams</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLIAMS</b>					22d. ADDRESS <b>122 S. CENTRE ST. CUMBERLAND, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>					25a. RECEIVED BY REGISTRAR <b>OCT 21 1960</b>		25b. REGISTRAR'S SIGNATURE <b>James S. ...</b>				

1931

1931

ALLEGANY

WYOMING

ALLEGANY

CLINTON

11 DAYS

COLUMBIA

ST. JAMES HOSPITAL, ALLEGANY, W. VA.

1931

1. 11. 1931

1. 11. 1931

1. 11. 1931

1. 11. 1931

1. 11. 1931

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*Handwritten notes and signatures, mostly illegible.*

1. 11. 1931

1. 11. 1931

1. 11. 1931

1. 11. 1931

1. 11. 1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10951

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10932

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>E.</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>10/28/1960</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/1896</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min.	11. IF UNDER 24 HRS. Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Garrett CO. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Beeman</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Leonard Wilson, Midland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Years</b> <b>5 Years</b> <b>5 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 10</b> 19 <b>55</b> , to <b>Oct 28</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct 25</b> 19 <b>60</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul R. Wilson, M.D.</b>		22b. DATE SIGNED <b>Oct 28, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson, M.D.</b>		22d. ADDRESS <b>Piedmont, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/30/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		ADDRESS <b>LONACONING, MD.</b>	
25a. REC'D BY REGISTRAR <b>DATE OCT 31 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

10933

10934



MAINTENANCE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
No. 10933  
Name: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Race: [illegible]  
Date of Birth: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Cause of Death: [illegible]  
Signature: [illegible]  
Official Seal: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10924

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10933

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA VALE Cumberland</b>		c. LENGTH OF STAY IN lb <b>17 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK &amp; MEMORIAL HOSPITAL AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>Walter</b> Last <b>WIMER</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>26</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 17, 1878</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired carpenter</b>		12. 10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13. FATHER'S NAME <b>ISAAC WIMER</b>		14. MOTHER'S MAIDEN NAME <b>MARY RAINES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>232-07-2079</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Coronary Artery Disease + Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/9</b> 19 <b>60</b> to <b>10/26</b> 19 <b>60</b> , that (I) <del>was</del> last saw the deceased alive on <b>Oct/26</b> 19 <b>60</b> , and that death occurred on <b>6:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter N. Himmler</b>		22b. DATE SIGNED <b>10/27/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter N. Himmler M.D.</b>		22d. ADDRESS <b>412 N. Mechanic St, Cumberland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/29/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harper Cemetery,</b>		23d. LOCATION (City, town, or county) (State) <b>Nr. Harmon, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>OCT 31 '60</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10934

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Bedford, PA.</u> b. COUNTY <u>Bedford, PA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bedford</u> Rt. # <u>3 Box #288</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>75X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>May</u> Last <u>Wolford</u>		4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James J. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Florence ? Grim</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. A. Robinette, Route 3, Bedford, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Arteriosclerotic cardiac and cerebrovascular dis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u> <u>2 1/2 months</u> <u>6 + years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelonephritis; old fractures of left arm and hip; osteoarthritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 5th, 1960</u> to <u>October 20th, 1960</u> , that (I) (we) last saw the deceased alive on <u>October 20, 1960</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Doerner</u>		22b. DATE SIGNED <u>10-21-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. Doerner</u>		22d. ADDRESS <u>Algonquin Hotel, Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 23, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Augusta, W. Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Meryl Combs</u>		25a. REC'D BY REGISTRAR <u>Oct 24 '60</u>	
ADDRESS <u>Romney, W. Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

MEDICAL CERTIFICATION

10334

CERTIFICATE OF DEATH

10335



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10926

## CERTIFICATE OF DEATH

Reg. Dist. No. 10935

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		d. STREET ADDRESS <b>Jane Frazier Village</b>	
3. NAME OF DECEASED (Type or print) <b>Stella</b> <b>First</b> <b>Rosettia</b> <b>Middle</b> <b>Yankee</b> <b>Lost</b>		4. DATE OF DEATH <b>Oct.</b> <b>2</b> <b>19</b> <b>60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia, Thomas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Eliza Nazelrod</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Hearst</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>James E. Leary, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X 422 Chronic Myocarditis</b> DUE TO (b) <b>450 General arteriosclerosis</b> DUE TO (c) <b>593 Chronic hepatitis</b>		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>304 Senile psychosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 19th, 1960</b> , to <b>Oct. 2nd, 1960</b> , that I last saw the deceased alive on <b>Oct. 1st, 1960</b> , and that death occurred at <b>4:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St., Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James E. McLean, MD.</b>		DATE SIGNED <b>10/3/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/5/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Allegany County Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 5 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

